Residential Treatment Services Rate Study
Division of Alcohol and Substance Abuse
Department of Social and Health Services, State of Washington

I. Introduction

Purpose of the Technical Assistance

In May 2003, the Washington Department of Social and Health Services Division of Alcohol and Substance Abuse requested assistance from the Center for Substance Abuse Treatment (CSAT) to help determine the appropriate rate structure for its residential treatment services.

CSAT is one of three centers of the Substance Abuse and Mental Health Services Administration (SAMHSA). The TA was provided under the State Systems Technical Assistance Project (SSTAP). Johnson, Bassin & Shaw, Inc. (JBS) is the SSTAP contractor. JBS is a health and housing consulting firm based in Silver Spring, Maryland. JBS contracted the services of James E. Sorensen, Ph.D. and CPA to deliver the TA.

The consultant provided onsite TA to the staff of the Washington Division of Alcohol and Substance Abuse on November 15-17, 2003 and August 4-5, 2004 and off-site consultation for 11 days. This report summarizes the State's issues, options, and methods for the determination of rates for its residential services.

Consultant's Background

James E. Sorensen is professor of accountancy in the School of Accountancy in the Daniels College of Business at the University of Denver, a position he has held since 1972. He teaches Not-for-Profit Accounting in the School of Accountancy and serves as the Strategic Cost Management coordinator for the integrated MBA for Daniels where he teaches the use of strategic cost management, the Balanced Scorecard (BSC), ISO-9000: 2000, decision support tools and related computer software.

Sorensen's work is often cited in the cost determinations of human service agencies. His behavioral health research includes cost-finding, cost-outcome and cost-effectiveness of human service programs. Dr. Sorensen's clients include federal, state and local behavioral health agencies and providers in every state in the United States as well as Puerto Rico and Guam.

Sorensen has published more than 100 articles. His research has appeared in the ***Journal of Behavioral Health Services & Research (formerly The Journal of Mental Health Administration), Administration and Policy in Mental Health, Management Accounting, Journal of Accountancy, The Accounting Review, Journal of International Accounting, Administrative Science Quarterly, Decision Sciences, Accounting, Organizations and Society,*** and six other journals.

II. Technical Assistance Report

A. Important Contextual Issues

The Division of Alcohol and Substance Abuse (DASA) established rates for its residential service several years ago and these rates have been adjusted periodically to compensate for inflation and other factors. There is a widespread allegation that the current reimbursement rates are not sufficient to provide the quality of services required by DASA program standards. Current concerns over the adequacy of the funding for residential services have emerged from the providers of residential services the State of Washington House of Representatives, and DASA itself. A central question to be addressed in this consultation is an assessment of the current unit of service costs for the multiple modalities of residential services contracted by DASA.

B. Description of the Methodology

In December 2003, a Residential Rate Study Advisory Committee was formed (see Appendix I) to guide the review and assessment of the residential reimbursement rates for the Division of Alcohol and Substance Abuse (DASA) service providers. The project was to produce usable rates based on the actual costs of providers that the Division of Alcohol and Substance Abuse can use in future State of Washington budgetary requests and in contracting with service providers.

Initial Visit. In an initial visit the consultant was able to visit six providers in the Seattle area. The interest and the willingness of providers to share financial and operational information was impressive. In those initial visits, the independent auditor's report was of substantial value. Generally Accepted Accounting Principles (GAAP) for voluntary health and welfare organizations require a functional cost report as part of the independent auditor's report. On the initial site reviews, all of the independent audit reports reviewed contained a functional costing of services and management and general administration. Some of the most powerful cost information about the costs of residential modalities emerges from the functional cost report since it is tied to the independent auditor's opinion about the fair presentation of the general financial statements. Using the independent auditors' reports for the costing of the modalities represented an enormous cost savings over a study that required an independent cost-finding on a site-by-site basis.

Second Phase. A review of the independent auditor's report from all of the providers of residential services would be a major step forward for DASA in assessing the costs of these modalities. In addition information on the units of service delivered for the time period that matches the reporting period of the auditor's report is required for the residential service as defined by the Division of Alcohol and Substance Abuse. The calendar year 2003 or a fiscal year ending somewhere in 2003 was the most appropriate reporting time period.

Submission of Auditor Reports, Units of Service and Level of Service. The independent audit reports of residential providers along with defined units of services and the State designated level of service was needed to advance the study of residential rates. Armed with the functional costs of the modalities, the costs of management and general administration and the annual units of service

provided by modality, a cost-finding process was completed to determine the various residential rates by eight modalities. The modalities included

- Intensive Inpatient Treatment
- Long-term Residential
- Recovery House
- Long-term—Involuntary
- Pregnant and Parenting Women (PPW) Residential
- Youth—Level 1
- Youth—Level 2
- Youth—Level 2 Secure

While the independent audit report functional cost report has the rigor of the auditing process, the units of service might not come from a system with as many internal controls that characterize financial reporting systems. The independent auditor is likely to have done a substantive review of the internal controls that produced the financial statements on which s/he is expressing an opinion. Providers were asked to provide a narrative summary of the process to collecting units of service and a description of any checks or controls used to assure the unit counts are correct. (The list of invited providers [Appendix IV] was included in earlier versions of this report, but the consultant was asked by the Executives of DASA as well as the Residential Rate Study Advisory Committee to delete this list in the final report. Only the introduction to Appendix IV has been retained.)

C. State of Washington Procedures[1]

How are data Collected? DASA collects data through a Management Information System (MIS) called TARGET (Treatment and Assessment report Generation Tool). Each treatment program enters the following information into TARGET on a monthly basis: client's name, number of days in treatment, the date a client was admitted or discharged, modality, contract type, funding source, as well as other client information. The MIS staff pulls a report on the 12th day of each month, and an invoice is generated based on the information the treatment provider has entered.

How are the units of service calculated? DASA pays treatment providers a rate for each bed based on the modality of treatment a client receives. The maximum amount of funding cannot exceed the number of beds stated in a binding contract between DASA and the treatment provider. [The units of service provided by this DASA reporting system are used in Figure 2 on the typical deficiency of reimbursement.]

Why was there a rate change from fiscal year 2003 to fiscal year 2004? DASA adjusted Adult Residential and Pregnant and Parenting Residential rates for intensive inpatient, long term residential, and recovery house to include clothing and personal incidental (CPI) expenses while a client is in treatment.

[1] Clarey, Melissa [claremm@dshs.wa.gov] e-mail dated March 19, 2004.

D. Reports on and Interpretations of the Results

Costs exceed rates. Table 1 (Appendix II) summarizes the usable data (n = 22) submitted by invited providers. ***In nearly all instances the actual cost of the services exceeded the FY2003 reimbursement rates***. One exception is Long-Term Residential where one major provider is producing the service at a cost close to the reimbursement rate. Two Youth—Level 2 Secure providers are close to or below the reimbursement rate as well. All of the other illustrative providers revealed costs that exceeded reimbursement rates by a substantial amount.

Price-level adjustments. Price level adjustments to bring the report to 2004 price levels and to FY 2004 rates for comparison were not performed since the price level adjustments for the State of Washington were minor adjustments to the substantial gap between costs and reimbursement rates. As might be expected, the price-level adjustments only worsen the pre-existing gaps by a percentage point.

Protection of providers. This report tries to protect the providers from revealing data that can be specifically related to the individual providers. The providers were concerned generally about being singled out in the analysis so the cost of service reports are as clear as possible, but without identifying any specific provider. (See Appendix IV for the explanations of non-participation by invited providers. Some providers (n = 2) did **not** have a functional cost report in the independent audit that was at the level required for this study. Others (n = 3) declined to participate. As requested by Executives of DASA as well as the Residential Rate Study Advisory Committee the names of specific providers were deleted.

Typical providers. In the case of the Intensive Inpatient Treatment one provider (that was operating at a much lower level of utilization) was excluded to present the more "typical" provider. The unit cost is reduced from $115.61 to $109.83. In the case of Youth Level—1, one provider was operating at a lower level of utilization so a single, more typical provider is featured at $187. In two instances, Long-term—Involuntary and Youth—Level 2, the audits of the independent accountant did **not** have functional cost reports at the level of the residential modalities studied in this report. One Long-term—Involuntary provider was able to provide internal reporting information that has been shadow priced in Table 1, but the rates were not extended to Table 2 since the report was not part of a functional cost report from the independent auditor.

Variation in rates. Table 1 includes the ranges of the actual rates to give the reader a grasp for the empirical variability of these rates.

General and administrative rates. The "general and administrative" allocation to the residential service is expressed as a percentage of the **total costs of all services including the general and administrative costs.** Most of the rates are within the 15 to 20 percent range found in many human service programs of the size under review. Some of the rates (namely 7% and 26%) seem low or high, but these are for only one time period and the reader has to be careful about generalizations. “General and administrative” costs that are too low can be as

much of a problem as those that are too high. In the case of the high percentage, the root cause seems to be level of utilization (namely, lower than desired). The lower rate may suggest an administrative starvation (namely, more should be spent on administration).

Typical under-funding. Table 2 (Appendix II) examines the reimbursement provided to the illustrative providers with what it cost the illustrative provider to produce the service purchased by the State. Figure 2 gives a clearer estimate of the underpayment (in nearly all cases) and identifies the amount of cross-funding that appears to be happening to support the various residential treatment modalities purchased by the State of Washington. ***Based on the averages, DASA is under-funding its residential providers by 32% to 39% of the actual cost of the service***. Excluding those providers with nominal over-funding, serious under-funding for specific services varies from 29% (PPW Residential) to 66% (Intensive Inpatient Treatment). The Youth—Level 1 estimates at 75% used only one "typical provider" estimate and excluded the one provider that was underutilized.

Table 2, especially with an elaboration on the cross-funding, should be of significant value in demonstrating the under-funding crisis faced by many of the residential service providers within the State of Washington. In a number of interviews with providers, many mentioned they were not spending as much as they should be to adhere rigorously to program standards and to replace depreciating long-lived assets. While the study's report reflects the current actual costs, they do not reflect what the costs should be in the eyes of many providers. Additional analysis would be required to ascertain how much additional funding would be required besides the already noted cost reimbursement deficiency.

E. Recommendations and Impact

If the residential modality rates are not adjusted immediately, the residential service system faces an imminent collapse. While one or two services may survive, most can be expected to fail. In the illustrative sample (Table 2), providers were forced to cross-fund from $3.59 to $4.77 millions of dollars to deliver services only partially purchased by the State of Washington. While many of the providers receive private donations these donations do not match the cross-funding requirements. The shortfall estimates are for the illustrative providers used in this study and if the total system were evaluated, the cross-funding shortfall would be several times the $3.59 to $4.77 million estimate cited earlier. **As a summary observation for most of DASA residential services, the State of Washington is short-changing its providers.** (Appendix III offers suggested Responses to State of Washington Representative Ruth Kagi, Chair, House, Children & Family Services Committee.)

F. Outcomes

If DASA is able to convince the State of Washington Legislature of the dire funding situation for the residential service system, then this project and DASA efforts will be successful. If not, the residential provider system may implode with a catastrophic impact for the citizens of the State of Washington. The well-articulated DASA standards for quality of care for residential services will have no impact since most of the current providers will not be able to provide any services at any level. No private sector business would be expected to sell its

product or services at a 32% to 39% discount below cost (Table 2) with the expectation of survival, but that discounting is what DASA residential service providers are asked to do.

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Appendix I

RESIDENTIAL RATE STUDY
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Appendix II

(Separate Excel Spreadsheet)

Appendix III

Suggested Responses to
State of Washington Representative Ruth Kagi, Chair,
House Children & Family Services Committee

Memo

To: Emilio Vela

From: Jim Sorensen, Consultant

Date: September 22, 2004

Re: Responses to Representative Kagi's questions

Responses to questions about the Residential Rate Study

1. How will DASA contractors be compared to providers that are largely or solely privately funded?

   Response. Nearly all of the DASA contractors in the study use multiple funding sources. Many contracts are with other governmental agencies, but some are reimbursed by other third parties such as insurance companies or private pay. The proportions of the multiple funding sources vary greatly among the DASA contracted providers. None of the participants in this study is solely privately funded.

2. How will in-kind donations, debt service and reserve amounts, and special rates above and beyond the bed rate be incorporated into the study?

   Response. This is a complex question that requires a multi-part answer

   In-kind donations. The residential rate study uses the functional cost report contained in the financial statements prepared by the independent auditors (namely, the Certified Public Accountant or CPA). Voluntary Health and Welfare Organizations (VHWOs) are required to present a Statement of Functional Expenses to be in accord with Generally Accepted Accounting Principles (GAAP). This statement of functional expenses requires a determination of the costs of program services and supporting services (with the latter including management and general and fund raising expenses). This statement presents the expenses incurred for each program or function in detail by object of expenditure (namely salaries, benefits, supplies, travel, etc.). Most of the DASA contractors are VHWO organizations and, therefore, are required

to present a Statement of Functional Expenses as part of a general audit by an independent accountant (or CPA).

Under GAAP, donated materials, facilities and services follow strict rules. The fair market values of donated materials are reported as expenses when the material are used or sold. The same is true for donated (free) use of facilities and other assets. **Donated services** are recognized also if they

a. Require specialized skills (e.g., trained clinical skills, accounting, plumbing)
b. Are provided by individuals with those skills, and
c. Would have to be purchased typically if they were not donated to the organization

These latter criteria are restrictive and prevent recording many volunteer services in assisting staff members' work with agency clients.

Donations are noted in several of the independent financial accountant's report, but they are small in amount in most cases. In all likelihood many "volunteer" services did not meet the strict criteria and, therefore, are not recognized in the financial statements.

Debt service and reserve amounts. Payments on long-term obligations are reductions of liabilities (not expenses). Often there is confusion about payments on obligations like mortgages when the payment is viewed as an expense. An expense would be created if the mortgage was for a depreciable asset such as a building and the expense would be shown as a building depreciation expense. The amount of the mortgage payment and the amount of the depreciation expense may be two different numbers depending on the term of the mortgage and the life of the asset subject to depreciation. It is improper accounting to list the debt payment as an expense.

A reserve may be established as a separate segregation of assets. If an agency has a positive cash flow from operations (a normal expectation of a financially viable organization), for example, the management (or board) may chose to restrict assets for future purposes (such as replacement of existing facilities). These reserves are usually long-term assets (and are usually invested to produce interest or dividends) and they would appear on the Statement of Financial Position as a long-term asset.

Special rates above and beyond the bed rate. The functional cost report (at its best) will break out the cost of the modality (namely, intensive inpatient treatment, long-term residential, recovery house, intensive inpatient—involuntary, PPW intensive inpatient, youth—level 1, youth—level 2, and youth—level 2 secure). These cost summaries do not separate clearly costs related to food and housing. For example, the salary costs may include the treating therapist as well as support personnel. In other cases, food costs may be part of the administration and general that is prorated to the various services provided. The current study will be able to evaluate the total unit cost of service

by modality, but will not be able to separate the total unit costs into its component parts without a much more complex study requiring substantial additional funding.

3. How will the rate study address changes in demographics of persons using residential treatment and how such changes impact the cost of services?

   Response. The range of the modalities (namely, intensive inpatient treatment, long-term residential, recovery house, intensive inpatient—involuntary, PPW intensive inpatient, youth—level 1, youth—level 2, and youth—level 2 secure) is in response to differing needs of clients. Typically more intensive levels of service cost more and are reimbursed at higher levels. For example, a client may start with intensive inpatient treatment (a more expensive service) and then move to long-term residential (a less expensive service). Another example may be a youth moving from level 2-secure (a more expensive service) to a level 1 (a less expensive service). This may be described as a continuity of care continuum where client needs and client services are addressed so as the client need changes so does the service.

   If the question is related to the geographic location of the client, then additional information about where needs exist and what services are available should be presented (namely, a needs assessment and service capacity study).

4. What efforts are being made to identify and factor in variable staffing costs as well as the value of unpaid staff to determine the true cost of providing the service?

   Response. By separating the residential rates into modalities (namely, intensive inpatient treatment, long-term residential, recovery house, intensive inpatient—involuntary, PPW intensive inpatient, youth—level 1, youth—level 2, and youth—level 2 secure) salary differentials are implied since the modalities require differing levels of professional training or credentials. Several participating vendors have commented, however, their actual costs are understated because they are unable to hire individuals with appropriate training or credentials that require higher compensation. Part of the provider concern stems from DASA rates that are not sufficient to cover appropriate staffing costs.

   To address this question more directly would require modeling of each modality with appropriately credentialed (or trained) personnel, competitive compensation and reasonable caseloads.

   The value of unpaid staff is difficult to assess in the financial statements given the strict provisions of Generally Accepted Accounting Principles explained in question 2. Underfunded programs may be supplementing their services with volunteers who do not meet the GAAP requirements to be included as an (donated) expense, but nonetheless provide valuable assistance in delivering services. There is no known database that can answer this question directly.

5. How will staff salaries among providers be compared to staff salaries of comparable positions in [the] [S]tate (DOC, DASA, JRA, DCFS) and county agencies?

   Response. This study was not funded to do salary comparisons among various State agencies. The primary objective of this study was to assess the actual cost per unit of service for residential modalities.

6. To what extent will economy of scale be factored into the calculations? In other words, a 16-bed facility can be expected to have a higher per-bed cost than a 40-bed facility. Likewise, when group size is limited by regulation to 12 adults per group, it costs as much to provide counseling staff for a 16-bed facility as for a 24-bed facility. However, if Medicaid-funded, that 16-bed facility has no ability to raise revenues to offset its cost since its funding source does not allow anymore than 16 beds.

   Response. Your illustrations make an important point about the economy of scale. Spreading fixed costs (e.g., facilities) or committed variable costs (e.g., staffing) over a larger number of clients and/or services will lower the unit cost of service. Pitted against the benefit of lower unit costs are the concerns for the quality of the service in clinician qualifications, caseload and client outcomes. Many of the regulations may be focused on quality and without an express concern for the costs involved. Often, if the quality is to be held constant, the rate for the unit of service must be increased in order to sustain the service. To prevent a reduction of services, increased funding resources are needed to pay the higher rates.

   There may be some limited ability to compare providers of different size (or different sized locations within a given provider) to assess the impact of scale. The database for the study (namely, the number of providers across eight modalities) does not offer a huge opportunity to assess the impact of size on unit costs, but we will try to the extent possible to formulate this analysis.

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Appendix IV

Reasons for Non-participation by Invited Providers of Residential Services

Memo

To: Emilio Vela, Division of Alcohol and Substance Abuse

From: Jim Sorensen, Consultant, Residential Treatment Services Rate Study

Date: July 28, 2004 (revised August 5, 2004)

Re: Reasons for exclusion of recommended residential treatment providers; units of service needed; potential addition of Detox Services

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Reasons for Exclusion

One of the strengths of the study is the use of the independent auditor's report on the costs of the modalities and the "management and general" costs. Since the auditor is required by generally accepted accounting principles to show functional costs for voluntary health and welfare organizations, we have an excellent source of cost information. If an organization did not have an independent audit or if an organization could not provide detailed cost information that reconciled to the independent audit, the organization was excluded. This exclusion was to strengthen the Residential Treatment Services Rate Study report by relying on the assurances of the independent auditor. The other primary reason for exclusion was "no data submission."

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I hope these explanations are clear and useful. Please let me know if you have other questions.

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